

CLAIM WEEK

Enter Saturday Date

WEEKLY REQUEST FOR ALLOWANCE BY WORKER IN TRAINING

TRADE ACT OF 1974 AMENDED 2015

WORKER NAME (last, First, Middle)		STATE ID (SID)	PETITION NUMBER	
MAILING ADDRESS		CITY		STATE
				ZIP

A. TRADE READJUSTMENT ALLOWANCE *(To be completed by worker.)*

1. HAVE YOU FILED FOR ANY OTHER TRAINING ALLOWANCE FOR THE WEEK SHOWN (OR FOR A PERIOD WHICH INCLUDES THE WEEK)? ☐ YES ☐ NO IF YES, PROVIDE: PROGRAM TITLE _____

2. ARE YOU FILING A CLAIM FOR UNEMPLOYMENT INSURANCE IN ANY STATE? ☐ YES ☐ NO PAYING STATE _____

3. DURING THE CLAIM WEEK DID YOU WORK OR EARN ANY WAGES? ☐ YES ☐ NO IF YES, AMOUNT(*before taxes*) \$ _____

a. WERE YOU: QUIT LAID OFF DISCHARGED

4. IF YOU HAVE RETURNED TO WORK, PROVIDE:

EMPLOYER NAME _____	JOB TITLE/DUTIES _____
MAILING ADDRESS _____	_____
CITY, STATE, ZIP _____	_____
PHONE NUMBER _____	_____
WAGE PER HOUR \$ _____ HOURS PER WEEK _____	DATE BEGAN WORK _____
HAVE YOU WORKED FOR THIS EMPLOYER BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS JOB SPONSORED BY A STATE OR FEDERAL PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF PROGRAM _____

5. ARE YOU CURRENTLY ENROLLED IN TRADE ADJUSTMENT ASSISTANCE TRAINING? ☐ YES ☐ NO

a. IF YES, PROVIDE: TRAINING TITLE _____

b. TRAINING IS: ON-LINE (DISTANCE LEARNING) CLASSROOM (ON CAMPUS)

c. DAYS YOU ATTENDED THIS WEEK SUN MON TUE WED THU FRI SAT

d. (*Complete if applicable*) LODGING AND MEALS WERE PROVIDED THIS WEEK IN THE AMOUNT OF \$ _____ PER DAY FOR _____ DAYS

B. WORKER CERTIFICATION

I hereby file a claim for benefits and certify that I am enrolled in training as approved under the Trade Act. The information I have provided is correct to the best of my knowledge. I understand there are penalties for willful misrepresentation made to obtain allowance to which I am not entitled.

SIGNATURE OF WORKER _____ DATE _____

C. PROGRESS AND ATTENDANCE IN TRAINING *(To be completed by the training facility.)*

1. AS OF THE WEEK SHOWN, WAS THIS WORKER ATTENDING TRAINING ? ☐ YES ☐ NO

CURRENT TERM BEGAN: _____ CURRENT TERM ENDED: _____

IF NO, PLEASE EXPLAIN _____

IF STUDENT IS OUT ON BREAK: DATE BREAK BEGAN: _____ DATE STUDENT WILL RETURN _____

D. TRAINING FACILITY CERTIFICATION

THE ANSWERS TO PART C ARE IN ACCORDANCE WITH OUR RECORDS. THE WORKER IS SUBJECT TO ALL TRAINING FACILITY CRITERIA FOR SATISFACTORY PROGRESS.

NAME OF TRAINING FACILITY: _____ TELEPHONE NUMBER: _____ FAX NUMBER: _____ SIGNATURE OF TRAINING OFFICIAL _____ DATE _____	MAIL, FAX, OR EMAIL TO: TRA UNIT TN DEPT OF LABOR AND WORKFORCE DEVELOPMENT P O BOX 280450 NASHVILLE, TN 37228 EMAIL CGUI.TRACLAIMS@TN.GOV FAX: 615-532-3374
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